Polk County Health Department

2019 Influenza Vaccine School Consent Form
Polk County Health Department

Private Nasal	VFC Nasal
Private IM.	VFC IM

STUDENT'S NAME (Last)	(First)	(M.I.)	GRADE	TEACHER	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	STUDENT'S BIRTH DATE (m/d/y) / /	AGE	GENDER M / F
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP	SCHOOL		

Please answer the following questions by circling "YES" or "NO". We need this important health information to decide if your child should receive this vaccine and if they can receive the nasal or shot type of vaccine

1. Does your child have a serious allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list: _____	YES	NO
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO
5. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? If yes, please indicate type and date. Vaccine: _____ Date given: month_____day_____year_____	YES	NO
6. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? Please list: _____	YES	NO
7. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
8. Does your child have a weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	YES	NO
9. Is your child pregnant?	YES	NO
10. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	YES	NO
11. Has your child received influenza vaccine in prior years?	YES	NO
12. Do you prefer your child get one type of vaccine over another? If "YES" check which kind of vaccine below that you want your child to receive. **Your child may not receive this preferred vaccine if he/she has a medical concern related to the vaccine or if that vaccine is unavailable.** _____ Flu Mist (intranasal) _____ Injectable (Intramuscular) If preferred vaccine is not available, do you still want us to vaccinate your child? Yes No (Circle One)	YES	NO

Please circle "YES" or "NO" for each consent item, complete insurance information and sign below. Your child will not receive influenza vaccination without a parent or guardian signature.

1. I consent to sharing influenza immunization data with the Wisconsin Immunization Registry (WIR) so that my clinic/doctor is aware that my child has received this vaccine.	YES	NO
2. Please **circle** the best description of your child's health insurance coverage: Badger Care Health Insurance, vaccines covered Health Insurance, vaccines not covered No health insurance		
3. If my child is covered by health insurance, I consent to allow the Polk County Health Department to bill my insurance company for the administration of influenza vaccine. I understand that there is no cost to me. Please complete this section or attach a copy of your child's insurance card. Name of Health Insurance Plan/Company: _____ Group # _____ ID#_____ Subscriber's Name _____	YES	NO

I have read the Vaccine Information Statements dated 8/15/19 for the influenza vaccine and understand the risks and benefits. By signing this consent form I give permission to the Polk County Health Department to administer influenza vaccine to the child listed above.

Parent or Guardian Signature: _____ Date: _____